# Oasis HEALTH SPA

# Treatment Intake Form & Consent to Treat

*720 North 30th Street ~ Billings, MT 59101 ~ Phone (406) 294-7778 ~ Fax (406) 545-0044*

Name_____Date_____

DOB_____If patient is a minor, parent/guardian's name_____

Home Phone_____Cell Phone_____Email address_____

Do you authorize Oasis Health Spa to contact you at the above phone number(s) for reminder calls? Y N

Mailing Address_____

City_____State_____ZIP Code_____

Can we send you discounts/specials via email or home address? Y N

Emergency Contact Name_____Phone Number_____

How did you hear about us? _____

**Please check the following conditions that <u>currently</u> apply to you:**

| | | | |
|---|---|---|---|
| Cancer of any kind or history of cancer | | Tendency toward lightheadedness or fainting | |
| Frequent Headaches | | Bothered by heat, in general | |
| Recent surgery | | Blood clots | |
| Pregnant/Breastfeeding | | Heart Condition or has Pacemaker | |
| High or Low Blood Pressure | | Fast or irregular heartbeat | |
| Allergies to nuts | | Multiple Sclerosis | |
| Abdominal Pain | | Head Injuries/Concussions | |
| Lung condition such as Asthma | | Coordination problems | |
| Diabetes | | Broken bones or pins in bones | |
| Vascular Disease or blood thinners | | Numbness/Tingling | |
| Skin Condition/Rash | | Tendency toward lightheadedness or fainting | |
| Varicose veins | | Bothered by heat, in general | |
| Open wound or sore | | Rheumatoid Arthritis | |
| Sunburn | | Osteoarthritis | |
| Other: _____ | | | |

**Please List Your Goals For This Treatment**

_____

_____

**Past Treatments For Health Concern** (Chiropractic, Acupuncture, Physical Therapy, etc)

_____

**Do You Have Any Limitations In These Areas?** (Please Describe)

Work_____ Home/Family_____

Sleep/Self Care_____ Social/Recreational_____

**Health History** (Surgeries, Injuries, Accidents, Hospitalizations, & Major Illnesses - Include Dates)

_____

_____

**Habits** (Describe Type and Frequency)

Alcohol_____ Tobacco_____

Caffeine_____ Drugs_____

**What Do You Do For Work?**

_____

**Self Care Routines**

How do you reduce stress/pain/discomfort?_____

Exercise/Recreation? (Include Frequency & Duration) _____

Medications (Include Pain Relievers and Supplements)_____

## *Consent to Treat*

I understand that it is recommended I check with my personal physician before beginning any new treatment or health regime. I personally take responsibility for my decision to participate and receive treatment in the Oasis Health Spa and I do not hold Oasis Health Spa/Yellowstone Naturopathic Clinic, nor its staff, responsible for any adverse reactions I may experience as a result thereof. I also authorize the doctors of Yellowstone Naturopathic Clinic to provide any emergency services I may need while utilizing services here.

**Client's Signature** _____Date_____

Technician's Signature_____